Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN2918SNF | A. BUILDING _____ B. WING _____ | C 07/07/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HIGHLAND MANOR OF ELKO | 2850 RUBY VISTA DRIVE ELKO, NV 89801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z 000 | Initial Comments<br><br>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 7/6/09 and finalized on 7/7/09, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.<br><br>Complaint #NV00022068 was substantiated with deficiencies cited. (See Tag Z230)<br>Complaint #NV00021292 was unsubstantiated.<br><br>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.<br><br>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. | Z 000 | | |
| Z230 SS=E | NAC 449.74469 Standards of Care<br><br>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. | Z230 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| Z230 | Continued From page 1<br><br>This Regulation is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure Coumadin, an anticoagulant, was given as ordered for 1 of 7 residents (#7) and the effectiveness monitored for 1 of 7 residents (#2).<br><br>Findings include:<br><br>1. Resident #7 received the incorrect dosage of Coumadin from 5/1/09 through 5/9/09, the date of transfer to an acute care hospital.<br><br>2. The blood test to monitor the effectiveness Coumadin was below the expected range for Resident #2. For five days the nursing staff failed to confirm that the physician assistant received the test results to determine if a change in the dose was required.<br><br>Severity 2 Scope 2 | Z230 | | |